TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AZALEA ORTHOPEDICS

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-17-0248-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 30, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The two unlisted procedures were identified in the medical records (1. Microfracture technique to hamate and 2. Abrasion chondroplasty to lunate and triquetrum)…The carrier has improperly denied these charges again."

Requestor's Supplemental Position Summary: "No, we have not received payment for the unpaid charges. We got a response from them saying that they'd already paid us $2,999.14. While this is true, that payment was for a different set of charges (total billed amount was $13,615 and the $2999.14 payment was for charges with a billed amount of $10,615, leaving the 2 charges for $3,000 outstanding). In other words, this is not resolved."

Amount in Dispute: $3,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Azalea Orthopedic & Sports Medicine states that $3,000 is owed for this date of service and the carrier has not made any payments for this date of service. Enclosed find an explanation of bill review form showing the carrier paid $2,999.14 on 07/02/16 with check number 30731061. The payment is about as close as we can get to $3,000 and reflects what is due per the guidelines per out [sic] calculations."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 11, 2016	CPT Code 25999-59-LT (X2) Unlisted procedure, forearm or wrist	$3,000.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, requires in the absence of an applicable fee guideline, medical reimbursement shall be fair and reasonable.
4. Texas Labor Code §413.011 requires medical reimbursement to be fair and reasonable.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Claim/service lacks information which is needed for adjudication.
   - The payment for this service or supply should be established following review of the documentation by the insurance carrier.
   - Workers' compensation medical treatment guideline adjustment.
   - No additional reimbursement allowed after review of appeal/reconsideration.

Issues

Does the documentation support billing CPT code 25999(X2)? Did the requestor support amount sought is fair and reasonable reimbursement?

Findings

The requestor is seeking medical fee dispute resolution in the amount of $3,000.00 for CPT code 25999 that was denied payment based upon "Claim/service lacks information which is needed for adjudication."

The respondent states "Enclosed find an explanation of bill review form showing the carrier paid $2,999.14 on 07/02/16 with check number 30731061. The payment is about as close as we can get to $3,000 and reflects what is due per the guidelines per out calculations." A review of the submitted explanation of benefits finds that on the disputed date of service the requestor also billed codes 25275-LT, 29846-LT, 64721-59-LT, 25240-LT, and 25118-59-LT. The payment issued of $2,999.14 was for these codes, not 25999; therefore, CPT code 25999(X2) remains in dispute.

28 Texas Administrative Code §134.203(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers…"

CPT code 25999 is defined as "Unlisted procedure, forearm or wrist."

The requestor wrote "The two unlisted procedures were identified in the medical records (1. Microfracture technique to hamate and 2. Abrasion chondroplasty to lunate and triquetrum)." A review of the submitted Operative Report documents the unlisted procedures; therefore, the respondent's denial based upon a lack of information is not supported.

Per 28 Texas Administrative Code §134.203(f), states that "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

A review of Medicare's fee schedule finds no relative value unit or payment has been assigned to CPT code 25999; therefore, reimbursement is provided in accordance with 28 Texas Administrative Code §134.1.

28 Texas Administrative Code §134.1, requires that, in the absence of an applicable fee guideline, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar

circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

28 Texas Administrative Code §133.307(c)(2)(O) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." The Division reviewed the documentation submitted by the requestor and finds:

- The requestor does not discuss or demonstrate how the payment of $1,500.00/each for code 25999 (X2) would result in a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the proposed methodology.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. The Division therefore finds that the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/3/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.